

Intake Form

Date _____ Last Name _____ First Name _____

Address _____

City _____ State _____ Zip _____

Email Address _____

*Home Phone _____ Work Phone _____

Sex (M/F) _____ DOB _____

Is it acceptable to contact you at home? Y / N

If "no" then how can I contact you? _____

Are you currently under medical care? Y / N

If yes, then please explain/describe. _____

Name of Personal Physician & Phone Number: _____

Are you currently taking prescribed medications? Y / N

If yes, then please explain/describe. _____

List any psychiatric/mental health medications you have taken. _____

Have you been under the care of a psychiatrist, psychologist, or counselor? Y / N

If yes, please give the name, date, and location of the therapy and briefly explain the nature of the problem which required attention. _____
